State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

MEMORANDUM

Date: 18 July 2006

To: Helene Nelson
Secretary

C: Jason Helgerson
Executive Assistant

From: Linda McCart
PIC Director

Re: Economics of Mental Health & AODA Parity

This memorandum is in response to your request for information regarding the economics of mental health/AODA parity following the discussion of the benchmark plan for BadgerCare Plus.

Summary.
Numerous studies confirm that parity in mental health and AODA services are affordable and, when combined with carve-out forms of managed care, several organizations have seen reductions in costs.

"Moral hazard"—the tendency for people to demand more services as the price for services falls—is more apt to occur with mental health services than general medical services, but can be controlled through cost-controlling mechanisms in managed care, e.g., pre-certification and utilization review help ensure that only necessary and appropriate care is provided.

"Adverse selection"—the tendency of health insurance plans offering the most comprehensive coverage to attract those individuals most in need of care—is a significant problem with regard to mental health benefits and is difficult to control unless all available plans offer similar benefits. Several studies suggest that managed care is not effective in controlling adverse selection.

The proposed crowd out provisions recommended for BadgerCare Plus may limit the impact of adverse selection to a degree. The state would still run the risk that individuals would drop existing insurance coverage and wait the required time to be eligible for BC+. In addition, the addition of parity to BC+ may encourage private insurance to further reduce coverage for mental health and AODA services.

Costs.
The most recent study on parity suggests that the potential increase in health insurance premiums is less than half of one percent under managed care. This study—on the impact of parity in federal employees health benefits—also found that most users experienced a decrease in out-of-pocket spending, indicating that parity provided the intended additional financial protection for enrollees. Individual savings ranged from $8.78 to $87.06.

Studies of parity laws in Texas, Maryland, and North Carolina indicate that costs for mental health services declined when introduced with managed care legislation. In general, the number of users increased, with lower average expenditures per user.

Studies of employers who have experimented with increased access to mental health services report lower disability claims, higher productivity, and lower rates of absenteeism. In addition, there is some evidence that increased use of mental health services correlates with a comparable reduction in overall insurance expenditures on general health services.

RAND Health found that removing coverage limits only raises total insurance payments by about $1.00 per member per year.

Blue Cross/Blue Shield of Vermont saw the cost of providing mental health and substance abuse treatment increase from 2.3 percent of spending for all services to 2.47 percent, an increase of about 4 percent following implementation of parity. Monthly costs per beneficiary increased by 19 cents.

Managed care is essential to controlling costs through prior authorization, case management, network use, and other strategies.

Moral Hazard.
Moral hazard (or demand response) is based on the premise that insurance coverage induces individuals to use medical services that they would not have used had they been paying full cost.

Empirical evidence supports the view that consumers are more sensitive to changes in the price of mental health services than other health services under fee-for-service insurance arrangements. The RAND Health Insurance Experiment demonstrated that the increase in use of services by consumers in response to lower out-of-pocket costs was twice as great for outpatient mental health as for outpatient services as a whole.

Managed care arrangements appear to successfully address the moral hazard problem, at least in terms of limiting costs. The bigger concern among some advocates is than managed care reduces access to needed treatment.

Adverse Selection.
Adverse selection occurs when the market offers multiple plans with varying degrees of coverage, and individuals most in need of care gravitate towards plans offering the most generous benefits, causing increased costs in those plans.

According to the Surgeon General's Report on Mental Health, mental health is an area in which selection incentives appear to have a particularly strong impact. Inefficiently low levels of coverage for behavioral health may result if health plans compete to enroll persons who are considered to be good risks and avoid caring for high-cost, consistently ill patients. Plans may set low limits on the number of inpatient days and outpatient visits to send a

message to consumers with mental illnesses that they may be better off choosing another plan.

A clear example of adverse selection occurred in the 1970s when Aetna offered a parity benefit for mental health services to federal employees and Blue Cross/Blue Shield did not. Aetna quickly attracted a much "needier" population of enrollees, began losing money, and rescinded its benefit.

A recent national study found that employees with family members suffering from mental illness appear to seek out employment positions that offer more comprehensive mental health coverage.

Several studies, including the Surgeon General's report, suggest that managed care may exacerbate adverse selection and that efforts to regulate selection and erosion of coverage through parity may not produce the desired effect.

Impact.
Several studies have emphasized the importance of using managed care arrangements to help control costs of unlimited mental health and AODA services. To date, there have been few studies on the long-term impact of managed care on the quality of these services.

A study of a managed care mental health carve-out for Medicaid enrollees in Massachusetts found that the 30-day readmission rates for children receiving mental health services under the plan increased 10.1 percent following the carve-out.

A separate study of another managed care plan revealed that mental health services were targeted more intensely for reduced inpatient stay than general medical services, and each reduced inpatient day was associated with a 3.1 percent rise in patients' 60-day readmission rate.

A 2002 article in the *Harvard Journal on Legislation* (Vol. 39, Issue 1) suggests that outcomes under managed care may be even poorer for those with serious mental illnesses.

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